HEALTHCARE APPLICATION - WELLNESS TREE COMMUNITY CLINIC

Name: _____ **Date:** _____

Date of Birth: _____ **Email**: _____

Personal Phone: _____ **Work**: _____

Address: _____ **City:** _____ **St.** _____ **Zip**: _____

How do you prefer to be contacted? (please circle) Phone Call Text Email

How did you hear about us? (please circle) TV/Radio Friend/Family Provider Social Media

Other (Please Specify)_____

NOTES: Please answer all highlighted sections.

1. **Do you have Medicaid, Medicare, V.A., or other Health Insurance? Yes or No**
   If you have a health insurance policy that has a $5,000 deductible, or greater, and you cannot afford to see a doctor because of your deductible and low income, we still might be able to serve you. Subject to individual review and approval, we can see patients in this situation until their deductibles have been met. Once the deductible has been met you will no longer be eligible for our free services for the remainder of the year.
2. **How many people are in your household including you?** _____
3. **What is your average monthly or annual household income?** _____

   Please circle the correct answer for the size of your household:

   For a 1 person household, is your income less than $3,640 per month? **Yes or No**
   For a 2 person household, is your combined income less than $4,930 per month? **Yes or No**
   For a 3 person household, is your combined income less than $6,215 per month? **Yes or No**
   For a 4 person household, is your combined income less than $7,500 per month? **Yes or No**

   (For each additional family member: Add $1,285 to monthly figure.)

NOTES: Please read the following section carefully.

4. I understand that I must be responsible for all written prescriptions.
5. I understand that I must be responsible for hospital performed procedures, unless the charges are waived by them in advance. (Waivers or Vouchers need to be in writing.)
6. I understand that I must be responsible for services performed by medical specialists to whom I have been referred to by any Wellness Tree Community Clinic provider, unless the charges have been waived by the provider in advance. (In writing)
7. I understand that the Wellness Tree Community Clinic does not do examinations or paperwork for Disability Determinations, Social Security, or Workman's Comp.

_____ _____

APPLICANT DATE

*** IMPORTANT NOTICE ***

NO SHOWS: It is very important that you notify us if you cannot keep your appointment. Failure to show up will result in consequences. One (1) No-Show without prior notification will prompt us to place your name on our no-show patient list. Two (2) No-Shows without sufficient notification will eliminate you from being able to schedule future day-time appointments for the next year. (You may still come to evening walk-in clinics.)

Volunteer Health Care Provider Immunity

(Please read carefully)

Wellness Tree
COMMUNITY CLINIC

TITLE 39 – 7703 of Idaho Statues provides immunity from liability for Health Care Providers Providing Charitable Medical Care.

(1). Any healthcare provider who voluntarily provides needed medical or healthcare services to any person at a free medical clinic without compensation or the expectation of compensation due the inability of such person to pay for the services shall be immune from liability for any civil action arising out of the provision of such medical or health services.

(2). Immunity pursuant to subsection (1) of this section shall apply only if the healthcare provider and the patient execute a written waiver in advance of the rendering of such medical services specifying that such services are provided without the expectation of compensation and that the health care provider shall be immune as specified herein.

I certify that I have read and understand the above provisions of Title 39 of Idaho Statutes and that any questions I had concerning the above previsions were answered to my satisfaction.

_____ Date: _____
Patient Name

_____ Date: _____
Guardian Name (If applicable)

_____ Date: _____
Witness

<u>NOTE:</u> A copy of Idaho Statues Title 39 – 7703 will be provided to you if you so desire. Mark here if you would like a copy of the statute. ➡ (Y / N)

X_____
Signature of Patient (or Guardian)